		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029892

Facility Name: APOSTOLIC CHRISTIAN RESTHAVEN

Address: 2750 WEST HIGHLAND AVENUE (Number) ELGIN (City) 60123 (Zip Code)

County: KANE

Telephone Number: 847-741-4543 **Fax #** 847-741-4562

IDPA ID Number: 36-2732524001

Date of Initial License for Current Owners: 11/07/1985

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: David Stieglitz, Administrator **Telephone Number:** 847-741-4543

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from Jan. 1, 2003 to Dec. 31, 2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) David Stieglitz
(Title) Administrator

Paid Preparer
(Signed) An accountants' compilation report is attached (Date)
(Print Name and Title) Lawrence F. Lenard, Partner
(Firm Name & Address) Borhart Spellmeyer & Company, 2205 Point Blvd, Suite 160, Elgin, IL 60123
(Telephone) 847-695-1775 Fax # 847-695-1984

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	50	TOTALS	50	18,250	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,060	5,802		8,862	8
9	SNF/PED					9
10	ICF	1,733	7,434		9,167	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,793	13,236		18,029	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.79%

D. How many bed-hold days during this year were paid by Public Aid?
26 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
meals, hair care, personal care for apartment residents

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 11/07/1985

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: December 31 Fiscal Year: December 31

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	217,875	9,420		227,295		227,295		227,295			1
2	Food Purchase		86,570		86,570		86,570	(16,906)	69,664			2
3	Housekeeping	54,960	9,372		64,332		64,332		64,332			3
4	Laundry	33,174	4,292		37,466		37,466		37,466			4
5	Heat and Other Utilities			58,748	58,748		58,748		58,748			5
6	Maintenance	56,546	115	24,886	81,547		81,547		81,547			6
7	Other (specify):*											7
8	**TOTAL General Services**	362,555	109,769	83,634	555,958		555,958	(16,906)	539,052			8
	B. Health Care and Programs											
9	Medical Director			2,000	2,000		2,000		2,000			9
10	Nursing and Medical Records	1,144,331	9,669	8,338	1,162,338		1,162,338	25	1,162,363			10
10a	Therapy		5	2,820	2,825		2,825		2,825			10a
11	Activities	54,229	5,508	2,208	61,945		61,945	250	62,195			11
12	Social Services	24,116	279	1,518	25,913		25,913		25,913			12
13	Nurse Aide Training			3,548	3,548	(3,548)						13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,222,676	15,461	20,432	1,258,569	(3,548)	1,255,021	275	1,255,296			16
	C. General Administration											
17	Administrative	79,758			79,758		79,758		79,758			17
18	Directors Fees											18
19	Professional Services			30,810	30,810		30,810		30,810			19
20	Dues, Fees, Subscriptions & Promotions			5,603	5,603		5,603	(775)	4,828			20
21	Clerical & General Office Expenses	38,769	7,846	4,097	50,712		50,712		50,712			21
22	Employee Benefits & Payroll Taxes			377,902	377,902	14,699	392,601	992	393,593			22
23	Inservice Training & Education			7,679	7,679	833	8,512		8,512			23
24	Travel and Seminar			393	393	2,715	3,108	(2,833)	275			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			42,976	42,976		42,976		42,976			26
27	Other (specify):* see schedule			14,854	14,854	(14,699)	155	(71)	84			27
28	**TOTAL General Administration**	118,527	7,846	484,314	610,687	3,548	614,235	(2,687)	611,548			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,703,758	133,076	588,380	2,425,214		2,425,214	(19,318)	2,405,896			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN #0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			123,861	123,861		123,861	(28,176)	95,685			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(11,046)	(11,046)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			123,861	123,861		123,861	(39,222)	84,639			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		59,798	83,315	143,113		143,113		143,113			39
40	Barber and Beauty Shops	24,219	153	921	25,293		25,293		25,293			40
41	Coffee and Gift Shops		1,170		1,170		1,170	(1,170)				41
42	Provider Participation Fee			27,375	27,375		27,375		27,375			42
43	Other (specify):* see schedule		942	61,444	62,386		62,386	(61,444)	942			43
44	**TOTAL Special Cost Centers**	24,219	62,063	173,055	259,337		259,337	(62,614)	196,723			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,727,977	195,139	885,296	2,808,412		2,808,412	(121,154)	2,687,258			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(17,136)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,499)	30		9
10	Interest and Other Investment Income	(11,046)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(66)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(26,677)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(175)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(600)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (57,199)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (57,199)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

APOSTOLIC CHRISTIAN RESTHAVEN

ID# 0029892

Report Period Beginning: Jan. 1, 2003

Ending: Dec. 31, 2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Out-of-state travel	$ (2,715)	24	1
2	Apartment expense	(61,444)	43	2
3	Vending expense	(1,170)	41	3
4	Volunteer expense	(5)	27	4
5	Non-care vehicle expense	(118)	24	5
6	Donated food	230	2	6
7	Donated nursing supplies	25	10	7
8	Donated activities	250	11	8
9	Donated staff appreciation/employee relations	992	22	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(63,955)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(16,906)	0	0	0	0	0	0	0	0	0	0	(16,906)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(16,906)	0	0	0	0	0	0	0	0	0	0	(16,906)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	25	0	0	0	0	0	0	0	0	0	0	25	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	250	0	0	0	0	0	0	0	0	0	0	250	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	275	0	0	0	0	0	0	0	0	0	0	275	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(775)	0	0	0	0	0	0	0	0	0	0	(775)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	992	0	0	0	0	0	0	0	0	0	0	992	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,833)	0	0	0	0	0	0	0	0	0	0	(2,833)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(71)	0	0	0	0	0	0	0	0	0	0	(71)	27
28	**TOTAL General Administration**	(2,687)	0	0	0	0	0	0	0	0	0	0	(2,687)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,318)	0	0	0	0	0	0	0	0	0	0	(19,318)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 **Report Period Beginning:** Jan. 1, 2003 **Ending:** Dec. 31, 2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(28,176)	0	0	0	0	0	0	0	0	0	0	(28,176)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,046)	0	0	0	0	0	0	0	0	0	0	(11,046)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(39,222)	0	0	0	0	0	0	0	0	0	0	(39,222)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(1,170)	0	0	0	0	0	0	0	0	0	0	(1,170)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(61,444)	0	0	0	0	0	0	0	0	0	0	(61,444)	43
44	**TOTAL Special Cost Centers**	(62,614)	0	0	0	0	0	0	0	0	0	0	(62,614)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(121,154)	0	0	0	0	0	0	0	0	0	0	(121,154)	45

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	27	Rent-land	$ 1	Apostolic Christian Church of Elgin	100.00%	$ 1	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1			$ 1	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: c. 31, 2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME APOSTOLIC CHRISTIAN RESTHAVEN COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0029892

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,600 B. General Construction Type: Exterior 80% brick/20% cedar Frame steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Eighteen (18) congregate housing units (apartments) are attached to the nursing home. Utilities are separately metered and costs are handled separately.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49		1985	1985	$ 2,033,874	$ 50,847	40	$ 50,847	$	$ 931,813	4
5			1986	1986	10,064	252	40	252		4,408	5
6			1987	1987	67,246	1,681	40	1,681		27,736	6
7	1		1988	1988	91,817	2,295	40	2,295		35,573	7
8			1999	1999	74,929	1,873	40	1,380	(493)	7,286	8
	Improvement Type**										
9	Land improvements			1985	24,667		15			24,667	9
10	Land improvements			1986	4,800		15			4,800	10
11	Land improvements			1989	2,069	138	15	138		2,012	11
12	Land improvements			1990	590	39	15	39		520	12
13	Land improvements			1992	3,525	235	15	235		2,703	13
14	Land improvements			1992	26,596	1,773	15	1,773		19,949	14
15	Land improvements			1997	15,126	1,008	15	1,008		6,468	15
16	Land improvements			1997	16,291	1,086	15	1,086		6,878	16
17	Land improvements-parking lot			2001	5,200	347	15	347		781	17
18	Land improvements-parking lot sealcoating			2001	2,095	140	15	140		315	18
19	Building improvements			1986	1,400	70	20	70		1,196	19
20	Building improvements			1987	8,669	433	20	433		7,028	20
21	Building improvements			1988	28,461	1,423	20	1,423		22,056	21
22	Building improvements			1989	500	25	20	25		367	22
23	Building improvements			1990	6,091	305	20	305		4,100	23
24	Building improvements			1991	6,846	342	20	342		4,178	24
25	Building improvements			1992	13,749	687	20	687		7,901	25
26	Building improvements			1992	1,331	67	20	67		770	26
27	Building improvements			1994	885	44	20	44		414	27
28	Building improvements			1995	18,458	1,850	10	1,850		15,809	28
29	Building improvements			1996	6,987	699	10	699		5,350	29
30	Building improvements			1996	809	40	20	40		307	30
31	Building improvements			1997	1,164	116	10	116		764	31
32	Building improvements			1998	2,100	105	20	105		604	32
33	Building improvements			1998	2,029	101	20	101		564	33
34	Building improvements			1998	2,671	267	10	267		1,446	34
35	Building improvements			1999	4,500	225	20	225		1,088	35
36	Building improvements			1999	3,882	194	20	194		922	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building improvements	1999	$ 389	$ 19	20	$ 19	$	$ 90	37
38	Building improvements	1999	310	15	20	15		75	38
39	Building improvements	1999	1,325	66	20	66		314	39
40	Building improvements	1999	985	49	20	49		229	40
41	Building improvements	1999	656	33	20	33		138	41
42	Building improvements-garbage disposal	2000	1,975	99	20	99		355	42
43	Building improvements-faucets	2001	104	5	20	5		13	43
44	Building improvements-faucets	2001	2,268	113	20	113		301	44
45	Building improvements-greasetrap	2001	3,769	188	20	188		501	45
46	Building improvements-door shades	2001	281	14	20	14		33	46
47	Building improvements-door shades	2001	281	14	20	14		32	47
48	Building improvements-damper	2001	710	35	20	35		77	48
49	Building improvements-door for PT room	2001	600	30	20	30		63	49
50	Building improvements-drapes employee dining room	2002	653	33	20	33		60	50
51	Building improvements-drapes residents	2002	1,307	65	20	65		114	51
52	Building improvements-electromagnetic front doors	2003	1,717	79	20	79		79	52
53	Building improvements-air conditioning	2003	3,100	65	20	65		65	53
54	Building improvements-fire dampers	2003	2,160	18	20	18		18	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,512,011	$ 69,647		$ 69,154	$ (493)	$ 1,153,330	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 201,036	$ 23,257	$ 23,257	$	5/10/20	$ 115,704	71
72	Current Year Purchases	18,295	928	928		5/10	928	72
73	Fully Depreciated Assets	191,332				10	191,332	73
74								74
75	TOTALS	$ 410,663	$ 24,185	$ 24,185	$		$ 307,964	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van	1996 National Mobility	1996	$ 33,525	$ 3,352	$ 2,346	$ (1,006)	10	$ 26,264	76
77										77
78										78
79										79
80	TOTALS			$ 33,525	$ 3,352	$ 2,346	$ (1,006)		$ 26,264	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,956,199	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 97,184	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 95,685	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,499)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,487,558	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments-1986/1990/1999	$ 924,274	$ 23,107	$ 345,122	86
87	Land improvements-1986/1990/1991/1997	94,036	2,646	64,094	87
88	Equipment-1986-1999	42,662	164	42,000	88
89	Building improvements-1999-2002	10,427	522	1,760	89
90	Building improvements-2003	9,531	238	238	90
91	TOTALS	$ 1,080,930	$ 26,677	$ 453,214	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	39-2	visits				3,845		3,845	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2/39-3	# of prescrpts		4,604	83,315	1,353	4,604	84,668	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): personal supplies	39-2					54,600		54,600	13
14	TOTAL			$	4,604	$ 83,315	$ 59,798	4,604	$ 143,113	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of Dec. 31, 2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 506,843	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	120,933		3
4	Supply Inventory (priced at cost)	19,932		4
5	Short-Term Investments			5
6	Prepaid Insurance	58,557		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 706,265	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,550,279		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	486,850		16
17	Accumulated Depreciation (book methods)	(1,941,759)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	37,099		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): deposits	400		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,132,869	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,839,134	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 28,911	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,518		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Income-advance billings	155,682		36
37	Accrued Expenses	5,888		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 303,999	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deposits-Apartments	193,800		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 193,800	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 497,799	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,341,335	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,839,134	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,326,846	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,326,846	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	14,489	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 14,489	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,341,335	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,495,327	1
2	Discounts and Allowances for all Levels	(134,095)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,361,232	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	975	6
7	Oxygen	253	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,228	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,820	13
14	Non-Patient Meals	8,338	14
15	Telephone, Television and Radio	60	15
16	Rental of Facility Space		16
17	Sale of Drugs	91,568	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(40)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 102,746	23
	D. Non-Operating Revenue		
24	Contributions	177,622	24
25	Interest and Other Investment Income***	11,046	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 188,668	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See schedule	169,027	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 169,027	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,822,901	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	555,958	31
32	Health Care	1,258,569	32
33	General Administration	610,687	33
	B. Capital Expense		
34	Ownership	123,861	34
	C. Ancillary Expense		
35	Special Cost Centers	231,962	35
36	Provider Participation Fee	27,375	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,808,412	40
41	**Income before Income Taxes (line 30 minus line 40)****	14,489	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 14,489	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,918	2,106	$ 54,891	$ 26.06	1
2	Assistant Director of Nursing	1,985	2,161	46,820	21.67	2
3	Registered Nurses	13,408	14,430	316,988	21.97	3
4	Licensed Practical Nurses	5,186	5,629	114,162	20.28	4
5	Nurse Aides & Orderlies	45,626	49,526	572,384	11.56	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,891	2,135	26,873	12.59	8
9	Activity Director	1,657	1,846	24,895	13.49	9
10	Activity Assistants	3,072	3,282	29,334	8.94	10
11	Social Service Workers	1,901	2,056	24,116	11.73	11
12	Dietician	1,984	2,118	42,371	20.01	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,949	17,598	175,504	9.97	15
16	Dishwashers					16
17	Maintenance Workers	3,752	4,106	56,546	13.77	17
18	Housekeepers	5,742	6,285	54,960	8.74	18
19	Laundry	2,754	3,149	33,174	10.53	19
20	Administrator	1,995	2,126	79,758	37.52	20
21	Assistant Administrator					21
22	Other Administrative	1,152	1,276	12,213	9.57	22
23	Office Manager					23
24	Clerical	3,024	3,327	38,769	11.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) barber/beauty	1,619	1,877	24,219	12.90	33
34	TOTAL (lines 1 - 33)	114,615	125,033	$ 1,727,977 *	$ 13.82	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	6	2,000	9-3	36
37	Medical Records Consultant	13	771	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	4,250	10-3	39
40	Physical Therapy Consultant	47	2,820	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,208	11-3	44
45	Social Service Consultant	24	1,518	12-3	45
46	Other(specify) Beautician	73	876	40-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	295	$ 14,443		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	160	3,317	10-3	52
53	TOTAL (lines 50 - 52)	160	$ 3,317		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Stieglitz	Administrator	0	$ 79,758
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,758

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Borhart Spellmeyer & Company	CPA	$ 14,983
Paychex, Inc.	Payroll services	4,506
Wagner Office Solutions	Office equipment maintenance	1,074
MCC Technology	Computer network support	1,600
Gardner & White	Form 5500 EBP	325
Achieve Healthcare	Medical software support	2,212
Deb Sauder	Computer support	4,485
United Methodist Homes & Services	Long-term care consulting	1,625
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 30,810

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,693
Unemployment Compensation Insurance	2,340
FICA Taxes	129,554
Employee Health Insurance	154,636
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Life insurance	1,394
Pension expense	43,757
Employee health services	2,528
Employee relations-see attached schedule	14,699
Employee relations-donated goods adjustment	992
TOTAL (agree to Schedule V, line 22, col.8)	$ 393,593

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	1,027
Health Care Worker Background Check	97
(Indicate # of checks performed 20)	
City restaurant license	140
Association dues	3,075
Chamber of Commerce	175
Publications/bulk mail license	274
Newsletter	600
Buying group/notary application fees	215
Less: Public Relations Expense	(175)
Non-allowable advertising	(600)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,828

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,715
In-State Travel	
Vehicle expense	393
Seminar Expense	
Less out-of-state travel	(2,715)
Less non-care vehicle expense	(118)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 275

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **LifeServicesNetwork 2,214; AAHSA 726**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **38,137** Line **39**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **27,375**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **no** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.

PAGE 19, SCHEDULE XVII

OTHER REVENUE, LINE 28

ACCOUNT		
8023	VENDING INCOME (NOTE: VENDING EXPENSE IS ALREADY ALREADY ADJUSTED OUT OF SCH. V, LINE 41)	1,638
6902	ACTIVITY	1,064
802	COOKBOOKS	468
8050	APARTMENTS	162,133
6911/8026	MISCELLANEOUS	3,724
		169,027

RECLASSIFICATION ENTRIES
2003 COST REPORT

Pages 3 and 4, Schedule V.

	Cost Center	Expense Category	Line #	Reclassification
1	General Administration	Inservice training	23-3	3,548
	Health Care and Programs	Nursing and medical r	10-3	-
	Health Care and Programs	Nurse aide training	13-3	(3,548)

- to reclassify expenses (A/C 7044) not related to nurse aides' training. Nursing college training was reclassified to Line 10 in accordance with 1999 desk audit letter dated 8/16/2002 (N/A in 2003).

2	General Administration	Employee benefits	22-3	14,699
	General Administration	Other	27-3	(14,699)

- to reclassify employee benefits consistent with 1989 IDPA adjustments (A/C 7911).

3	General Administration	Travel & seminars	24-3	2,017
	General Administration	Inservice training	23-3	(2,017)

- to reclassify out-of-state travel & seminar cost for 10/26-10/31/03 AAHSA annual meeting in in Denver, CO ($2,010) and other ($7) (see A/C 7853).

4	General Administration	Travel & seminars	24-3	698
	General Administration	Inservice training	23-3	(698)

- to reclassify out-of-state travel & seminar cost for June 2003 ASHFSA annual meeting in Atlanta, GA ($339) and August 2003 AmeriNet Central Meeting in Pittsburgh, PA ($359) (see A/C 7529).

C. General Administration Other expenses, Line 27	7841 Volunteer Expense	7911 Employee Relations	7850 Misc. Expense	Total
Volunteer pizza	5			
Plants, flowers		277		
Staff Christmas gifts		4,503		
Staff appreciation gifts, certificates, luncheon, cards, lunches, plants, awards		3,900		
Staff appreciation dinner		720		
Gifts for years of service anniversaries		525		
Christmas dinner		1,460		
Employee assistance program		2,025		
Other employee relations		1,289		
Rent-land			1	
6 paintings			149	
Column 4 total	5	14,699	150	14,854
Reclassifications:				
Employee benefits to Line 22	-	(14,699)	-	(14,699)
Column 6 reclassified total	5	-	150	155
Adjustments:				
Volunteer expense	(5)			(5)
Sales tax		(66)		(66)
Column 8 adjusted total	-	(66)	150	84

E. Special Cost Centers Other expenses, Line 43	8540 Apartment Expense	8530 Multi- Purpose Rm.	8508 Misc. Expense	Total
Apartment expense	61,444			61,444
Multi-purpose room expense		942		942
Miscellaneous expense			-	-
Column 4 total	61,444	942	-	62,386
Reclassifications-none				
Column 6 reclassified total	61,444	942	-	62,386
Adjustments:				
Apartment expense	(61,444)	-	-	(53,627)
Column 8 adjusted total	-	942	-	942

APOSTOLIC CHRISTIAN RESTHAVEN
TRAINING AND EDUCATION
2003 COST REPORT
FACILITY #0029892

Account	Account name	PAGE 3, SCHEDULE V., LINE NO. 13 Nurse Aide Training	23 Inservice Training & Education	24 Travel & Seminar	Total
7044	Nursing education	3,548			
7191	Social service education		582		
7230	Activities education		662		
7269	Hairdresser education (not classified on this line)				
7529	Dietary education		1,112		
7614	Maintenance education		-		
7820	Vehicle expense			393	
7853	Administrative education		2,919		
7926	Employee Hiring and Training		2,404		
	Column 4 total	3,548	7,679	393	11,620
	Reclassifications:				
	Nursing education to Inservice	(3,548)	3,548		-
	Nursing college training to Line 10	-			-
	AAHSA annual conference to Travel & Seminar		(2,017)	2,017	-
	ASHFSA annual conference to Travel & Seminar		(698)	698	-
	Column 6 reclassified total	-	8,512	3,108	11,620
	Adjustments: Out-of-state travel			(2,715)	(2,715)
	Adjustments: Non-care vehicle expense			(118)	(118)
	Column 8 adjusted total	-	8,512	275	8,787